KAMALA D. HARRIS
Attorney General of California
DIANN SOKOLOFF
Supervising Deputy Attorney General
SUSANA A. GONZALES
Deputy Attorney General
State Bar No. 253027
1515 Clay Street, 20th Floor
P.O. Box 70550
Oakland, CA 94612-0550
Telephone: (510) 622-2141
Facsimile: (510) 622-2270
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **YUSSUF MOHAMUD MOHAMED** **a.k.a. YUSSUF M. MOHAMED** **43555 Grimmer Boulevard, Apt. N2121** **Fremont, CA 94538** **Registered Nurse License No. 716011** Respondent.	Case No. 2013 - 170 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about November 26, 2007, the Board of Registered Nursing issued Registered Nurse License Number 716011 to Yussuf Mohamud Mohamed, also known as Yussuf M. Mohamed (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought in this Accusation and will expire on January 31, 2013, unless renewed.

///

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after its expiration.

6. Section 118, subdivision (b), of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

. . .

"(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action."

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

8. Section 4021 of the Code states:

"'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

9. Section 4022 of the Code provides:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only' or words of similar import.

"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import . . .

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

10. **"Dilaudid"** is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(J), and a dangerous drug pursuant to Code section 4022. Dilaudid is the trade name for the controlled substance Hydromorphone Hydrochloride.

11. **"Vicodin"** is a Schedule III controlled substance pursuant to Health and Safety Code section 11056 subdivision (e)(4), and a dangerous drug pursuant to Code section 4022. Vicodin is a trade name for the narcotic substance Hydrocodone.

12. **"Compazine"** is a dangerous drug pursuant to Code section 4022. Compazine is the brand name for the substance Prochlorperazine.

13. **"Vistaril"** is a dangerous drug pursuant to Code section 4022. Vistaril is a brand name for the substance Hydroxyzine.

14. **"Vancomycin"** is a dangerous drug pursuant to Code section 4022. Vancomycin is the brand name for the substance Vancomycin Hydrochloride.

15. **"Benadryl"** is a dangerous drug pursuant to Code section 4022. Benadryl is the brand name for the substance Diphenhydramine.

COST RECOVERY

16. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTS

17. Respondent was employed as a registered nurse at a facility in Minneapolis, Minnesota, beginning February 19, 2008, and until the termination of his employment on February 3, 2009. At a conference with the Minnesota Nursing Board Review Panel (Minnesota Review Panel), Respondent acknowledged some errors in his practice but stated that most of the reported errors were false and motivated by harassment and discrimination by his nursing supervisor. Respondent acknowledged that he was provided extended orientation to the unit to assist him with the development of his skills. The Minnesota Review Panel noted that Respondent had made some improvements in his practice.

18. Examples of Respondent's practice issues included, but were not limited to, the following:

a. During the day and evening shifts, Respondent was responsible for monitoring and assessing a patient's intravenous ("IV") catheter site during the infusion of fluids. At the beginning of the night shift, the oncoming nurse assessed the patient and found that the IV fluid had infiltrated into the patient's hand and forearm tissue and was rising above the patient's elbow, with weeping blisters on the patient's hand. The patient required an emergency surgical fasciotomy. At the Minnesota Review Panel conference, Respondent stated that he never observed any signs of IV infiltration during his shifts. Respondent stated that the facility's standard for monitoring IV sites was to observe for swelling or redness once or twice a shift and that he had done so. Respondent was unable to account for the development of the significant infiltration noted at the change of shift.

b. Respondent cared for a patient receiving total parenteral nutrition (TPN) and lipids. Respondent failed to monitor the patient's laboratory value to assure safe and effective

administration of the TPN. At the Minnesota Review Panel conference, Respondent was unable to articulate the laboratory values expected to be monitored during the TPN infusion and the purpose for monitoring those values.

c. Respondent cared for a patient whose treatment included penile traction and continuous bladder irrigation (CBI). The patient complained of suprapubic pain and Respondent loosened the traction without consulting with the physician or obtaining an order to do so. Respondent failed to inform the physician of the patient's discomfort and loosening the traction. Respondent also failed to accurately account for the amount of fluid infused through the CBI and the patient's urine output. At the Minnesota Review Panel conference, Respondent stated that he loosened the penile traction on the advice of another nurse. Respondent acknowledged that he was responsible for his action and stated that he was unaware that his action was beyond the scope of his practice. Respondent agreed it was his responsibility to account for the CBI fluid and the patient's urine output. Respondent indicated that this accounting was not possible because when he arrived for the start of the shift, the amounts were already inaccurate. Respondent was unable to articulate problem solving for this situation to assure accuracy while he was responsible for the patient's care.

d. Respondent administered IV Dilaudid to a patient whose pain rating was "4," which was the level at which the patient had previously been adequately treated with Vicodin. At the Minnesota Review Panel conference, Respondent stated that he administered Dilaudid to the patient instead of Vicodin because the patient requested it, there were valid orders for Dilaudid, and the patient was showing other indicators of pain, such as writhing. Respondent admitted that his documentation in the patient's record did not accurately or adequately reflect the patient's pain level or his rationale for changing the medication.

e. A patient had physician orders to receive Compazine and Vistaril by intramuscular (IM) injection. Respondent documented on the medication administration record (MAR) that he gave the medication by IM, but documented in the nurse's notes that he gave the medication by IV. When the oncoming nurse questioned the route Respondent chose, Respondent said he conferred with the pharmacist who said the medication could be given IV, and that was why he

administered it that way. Respondent was reminded that the medication was ordered to be given by IM injection. The next day, Respondent again documented administering the Compazine and Vistaril by IV. That afternoon, the patient's IV site infiltrated and required warm-packing. At the Minnesota Review Panel conference, Respondent stated that he administered Compazine and Vistaril to the patient by IM injection, but acknowledged that he documented administering the medication by IV. Respondent stated that this was a "documentation error." Respondent also stated that spoke to the physician and pharmacist about administering the medications by IV, but the orders were not changed so he administered them by IM.

f. A patient had a physician's order to receive Vancomycin by IV infusion. The order also required the patient to be pre-medicated with Benadryl prior to infusing the Vancomycin because the patient had previously experienced an extreme reaction to the Vancomycin. Respondent administered the Vancomycin to the patient, but did not administer the Benadryl as ordered. Another nurse clarified for Respondent that the Benadryl was ordered to be given prior to the Vancomycin. The next day, Respondent again administered Vancomycin to the patient without administering Benadryl first. Instead, Respondent administered the Benadryl one hour after the Vancomycin was infused. At the Minnesota Review Panel conference, Respondent stated that he did not pre-medicate the patient with Benadryl because it was ordered every six hours and it was not due prior to the time that the Vancomycin was due to be administered. Respondent acknowledged that he did not attempt to solve the medication timing issue.

g. A patient had a physician order to receive Potassium by IV infusion over an eight hour period. Respondent completed the Potassium infusion over a two and one-half hour period. When later questioned about this by a supervisor, Respondent stated that he did not program the infusion to run at the accelerated rate, and he suggested the patient had changed the infusion rate on the IV pump. At the Minnesota Review Panel conference, Respondent denied setting the Potassium IV infusion rate incorrectly. Respondent demonstrated that he could accurately calculate the infusion rate for this situation. Respondent was unable to adequately articulate the effects of high and low Potassium levels on cardiac function and the potential adverse effects of administering IV Potassium too rapidly. Respondent admitted that programming an IV pump

requires technical skill and it is unlikely that the patient would have been able to reset the infusion rate. Respondent admitted that it was his responsibility to monitor the infusion, including the rate, throughout the shift.

CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Out of State Discipline)
(Bus. & Prof. Code § 2761, subd. (a)(4))

19. Complainant hereby realleges the allegations contained in paragraphs 17 and 18 and each of their subparts above, and incorporates them as if fully set forth.

20. Respondent has subjected his registered nurse license to disciplinary action under Code section 2761, subdivision (a)(4), in that on or about December 2, 2010, in a disciplinary action before the Minnesota Board of Nursing (Minnesota Board), the Minnesota Board entered a Stipulation and Consent Order (Order), accepting Respondent's voluntary surrender of his Minnesota registered nurse license. The Minnesota Board's Order was based upon its determination that Respondent violated Minnesota Statutes section 148.261, by engaging in conduct constituting cause for discipline as set forth in Paragraphs 17 and 18, above. The Order prohibited Respondent from engaging in any act constituting the practice of nursing in the State of Minnesota. The Order permitted Respondent to petition for reinstatement of his license if he returned to Minnesota, but Respondent would be required to comply with various terms and conditions as set forth in the Order.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 716011, issued to Yussuf Mohamud Mohamed, also known as Yussuf M. Mohamed (Respondent);

2. Ordering Respondent to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: September 6, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SF2012900935
90254628.docx